

more comprehensive review of conditions of participation would determine if a deficient practice exists.

§ 488.720 Extended surveys.

(a) *Purpose of survey.* The purpose of an extended survey is:

(1) To review and identify the policies and procedures that caused an HHA to furnish substandard care.

(2) To determine whether the HHA is in compliance with one or more or all additional conditions of participation not examined during the standard survey.

(b) *Timing and basis for survey.* An extended survey must be conducted not later than 14 calendar days after completion of a standard survey which found that a HHA was out of compliance with a condition of participation.

§ 488.725 Unannounced surveys.

(a) *Basic rule.* All HHA surveys must be unannounced and conducted with procedures and scheduling that renders the onsite surveys as unpredictable in their timing as possible.

(b) *State survey agency's scheduling and surveying procedures.* CMS reviews each survey agency's scheduling and surveying procedures and practices to assure that the survey agency has taken all reasonable steps to avoid giving notice of a survey through the scheduling procedures and conduct of the surveys.

(c) *Civil money penalties.* Any individual who notifies an HHA, or causes an HHA to be notified, of the time or date on which a standard survey is scheduled to be conducted is subject to a Federal civil money penalty not to exceed \$2,000.

§ 488.730 Survey frequency and content.

(a) *Basic period.* Each HHA must be surveyed not later than 36 months after the last day of the previous standard survey. Additionally, a survey may be conducted as frequently as necessary to—

(1) Assure the delivery of quality home health services by determining whether an HHA complies with the Act and conditions of participation; and

(2) Confirm that the HHA has corrected deficiencies that were previously cited.

(b) *Change in HHA information.* A standard survey or an abbreviated standard survey may be conducted within 2 months of a change, or knowledge of a change, in any of the following:

(1) Ownership;

(2) Administration; or,

(3) Management of the HHA.

(c) *Complaints.* A standard survey, or abbreviated standard survey—

(1) Must be conducted of an HHA within 2 months of when a significant number of complaints against the HHA are reported to CMS, the State, the State or local agency responsible for maintaining a toll-free hotline and investigative unit, or any other appropriate Federal, State, or local agency; or

(2) As otherwise required to determine compliance with the conditions of participation such as the investigation of a complaint.

§ 488.735 Surveyor qualifications.

(a) *Minimum qualifications.* Surveys must be conducted by individuals who meet minimum qualifications prescribed by CMS. In addition, before any State or Federal surveyor may serve on an HHA survey team (except as a trainee), he/she must have successfully completed the relevant CMS-sponsored Basic HHA Surveyor Training Course and any associated course prerequisites. All surveyors must follow the principles set forth in § 488.24 through § 488.28 according to CMS policies and procedures for determining compliance with the conditions of participation.

(b) *Disqualifications.* Any of the following circumstances disqualifies a surveyor from surveying a particular agency:

(1) The surveyor currently works for, or, within the past two years, has worked with the HHA to be surveyed as:

(i) A direct employee;

(ii) An employment agency staff at the agency; or

(iii) An officer, consultant, or agent for the agency to be surveyed concerning compliance with conditions of

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participation specified in or pursuant to sections 1861(o) or 1891(a) of the Act.

(2) The surveyor has a financial interest or an ownership interest in the HHA to be surveyed.

(3) The surveyor has a family member who has a relationship with the HHA to be surveyed.

(4) The surveyor has an immediate family member who is a patient of the HHA to be surveyed.

§ 488.740 Certification of compliance or noncompliance.

Rules to be followed for certification, documentation of findings, periodic review of compliance and approval, certification of noncompliance, and determining compliance of HHAs are set forth, respectively, in §§ 488.12, 488.18, 488.20, 488.24, and 488.26 of this part.

§ 488.745 Informal Dispute Resolution (IDR).

(a) *Opportunity to refute survey findings.* Upon the provider's receipt of an official statement of deficiencies, HHAs are afforded the option to request an informal opportunity to dispute condition-level survey findings.

(b) *Failure to conduct IDR timely.* Failure of CMS or the State, as appropriate, to complete IDR shall not delay the effective date of any enforcement action.

(c) *Revised statement of deficiencies as a result of IDR.* If any findings are revised or removed by CMS or the State based on IDR, the official statement of deficiencies is revised accordingly and any enforcement actions imposed solely as a result of those cited deficiencies are adjusted accordingly.

(d) *Notification.* When the survey findings indicate a condition-level deficiency, CMS or the State, as appropriate, must provide the agency with written notification of the opportunity for participating in an IDR process at the time the official statement of deficiencies is issued. The request for IDR must be submitted in writing to the State or CMS, must include the specific deficiencies that are disputed, and must be made within the same 10 calendar day period that the HHA has for submitting an acceptable plan of correction.

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Subpart J—Alternative Sanctions for Home Health Agencies With Deficiencies

SOURCE: 77 FR 67165, Nov. 8, 2012, unless otherwise noted.

§ 488.800 Statutory basis.

Section 1891(e) through (f) of the Act authorizes the Secretary to take actions to remove and correct deficiencies in an HHA through an alternative sanction or termination or both. Furthermore, this section specifies that these sanctions are in addition to any others available under State or Federal law, and, except for the final determination of civil money penalties, are imposed prior to the conduct of a hearing.

§ 488.805 Definitions.

As used in this subpart—

Directed plan of correction means CMS or the temporary manager (with CMS/SA approval) may direct the HHA to take specific corrective action to achieve specific outcomes within specific timeframes.

Immediate jeopardy means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a patient(s).

New admission means an individual who becomes a patient or is readmitted to the HHA on or after the effective date of a suspension of payment sanction.

Per instance means a single event of noncompliance identified and corrected through a survey, for which the statute authorizes CMS to impose a sanction.

Plan of correction means a plan developed by the HHA and approved by CMS that is the HHA's written response to survey findings detailing corrective actions to cited deficiencies and specifies the date by which those deficiencies will be corrected.

Repeat deficiency means a condition-level citation that is cited on the current survey and is substantially the same as or similar to, a finding of a standard-level or condition-level deficiency citation cited on the most recent previous standard survey or on